

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
9154
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
69126

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> c. LENGTH OF STAY IN 1b <u>6 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westernport</u> d. STREET ADDRESS <u>123 Church St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>RILEY</u> Last <u>BOSLEY</u>		4. DATE OF DEATH Month <u>8</u> / Day <u>14</u> / Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1877</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Bosley</u>		14. MOTHER'S MAIDEN NAME <u>Florence Liller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. William Bosley, Westernport, Maryland</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arterio; sclerosis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>4 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 4</u> 19 <u>60</u> to <u>Aug. 13</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>aug. 13</u> 19 <u>60</u> , and that death occurred at <u>9PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. H. Wolverton, Sr.</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>J. H. Wolverton, Sr</u>		22d. ADDRESS <u>Piedmont, West Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 17, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		23d. LOCATION (City, town, or county) <u>Westernport, Maryland</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Boal</u>		25a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 18 '60</u>	
ADDRESS <u>Westernport, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

05100

RECEIVED

6616

1

CERTIFICATE OF DEATH

11-1-18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		M		65		JAN. 15, 1853	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PLACE OF DEATH	
1111 N. E. ST.		LABORER		HEART DISEASE		HOME	
DATE OF DEATH		HOUR OF DEATH		TEMPERATURE		PULSE	
NOV. 1, 1918		10:30 A.M.		101.0		90	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF INTERVIEW		HOUR OF INTERVIEW		TEMPERATURE		PULSE	
NOV. 1, 1918		10:30 A.M.		101.0		90	
SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

9155

CERTIFICATE OF DEATH

09128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Garrett b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL Oakland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt Nursing Home				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Addie Middle Belle Last Eshelman				4. DATE OF DEATH Month Aug. Day 9 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY New Hampshire		11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Howard				14. MOTHER'S MAIDEN NAME Luette Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Swager Address Mrs. Edith XXXXXX Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral vascular accident March 1960						INTERVAL BETWEEN ONSET AND DEATH 2 weeks years _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-6-60 , 19____, to 8-8-60 , 19____, that I last saw the deceased alive on 8-8-60 , 19____, and that death occurred at 8 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 8-9-60							
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.							
PHYSICIAN'S NAME (Type) James H. Feaster, Jr., M. D.				58 2nd. St., Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/11/1960		22c. NAME OF CEMETERY OR CREMATORY Davis		22d. LOCATION (City, town, or county) (State) Davis W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle ADDRESS Davis, W.Va.				24a. REC'D BY REGISTRAR DATE AUG 12 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9156

CERTIFICATE OF DEATH

09129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN TB 68 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fourth Street		e. STREET ADDRESS Fourth Street	
3. NAME OF DECEASED (Type or print) John McClellan Falkenstein		4. DATE OF DEATH Month August Day 13 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1862
9. AGE (In years last birthday) 98		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ethbell Falkenstein		14. MOTHER'S MAIDEN NAME Mary Jane Feather	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Miss Grace Falkenstein		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration + Uremia 561.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obstruction DUE TO (c) Incarcerated right Femoral Artery		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Arteriosclerotic Cardiovascular Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1959 to Aug 13, 1960 , that I last saw the deceased alive on Aug 13, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton M.D.		ADDRESS (Street, city or town, state) 77 Oak St., Oakland, Md.	
DATE SIGNED Aug 60			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/1960	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE AUG 18 60		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

CERTIFICATE OF DEATH

U.S. DEPT. OF HEALTH

MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

1913

1913

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09130

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BLOOMINGTON c. LENGTH OF STAY IN MD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) —		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W.Va. b. COUNTY KANAWHA c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Belle d. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) THOMAS LEE FARMER		4. DATE OF DEATH AUG. 2nd. 1960	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 23, 1938
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY DOW CHEMICAL	
11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Camillus FARMER		14. MOTHER'S MAIDEN NAME "Unobtainable"	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT —		Address —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL 816X DUE TO BROKEN LEGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE EXTENSIVE CHEMICAL BURNS DUE TO (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. —		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Tractor-trailer loaded with acid wrecked at bottom of Rt. 135 at Bloomington, Maryland.	
20c. TIME OF INJURY Month, Day, Year 5:05 a.m. 8-2-60 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Bloomington Garr., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. —	
EXAMINER'S NAME (Type) JAMES H. FEASTER, JR., M. D.		DATE SIGNED 8-2-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF Aug. 2, 1960	
22c. NAME OF CEMETERY OR CREMATORY —		22d. LOCATION (City, town, or country) (State) EAST BANK, W.Va.	
23. FUNERAL DIRECTOR E. S. Beral		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR —		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

06120

UNITED STATES DEPARTMENT OF JUSTICE

1977



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9157

CERTIFICATE OF DEATH

09131

Reg. Dist. No.

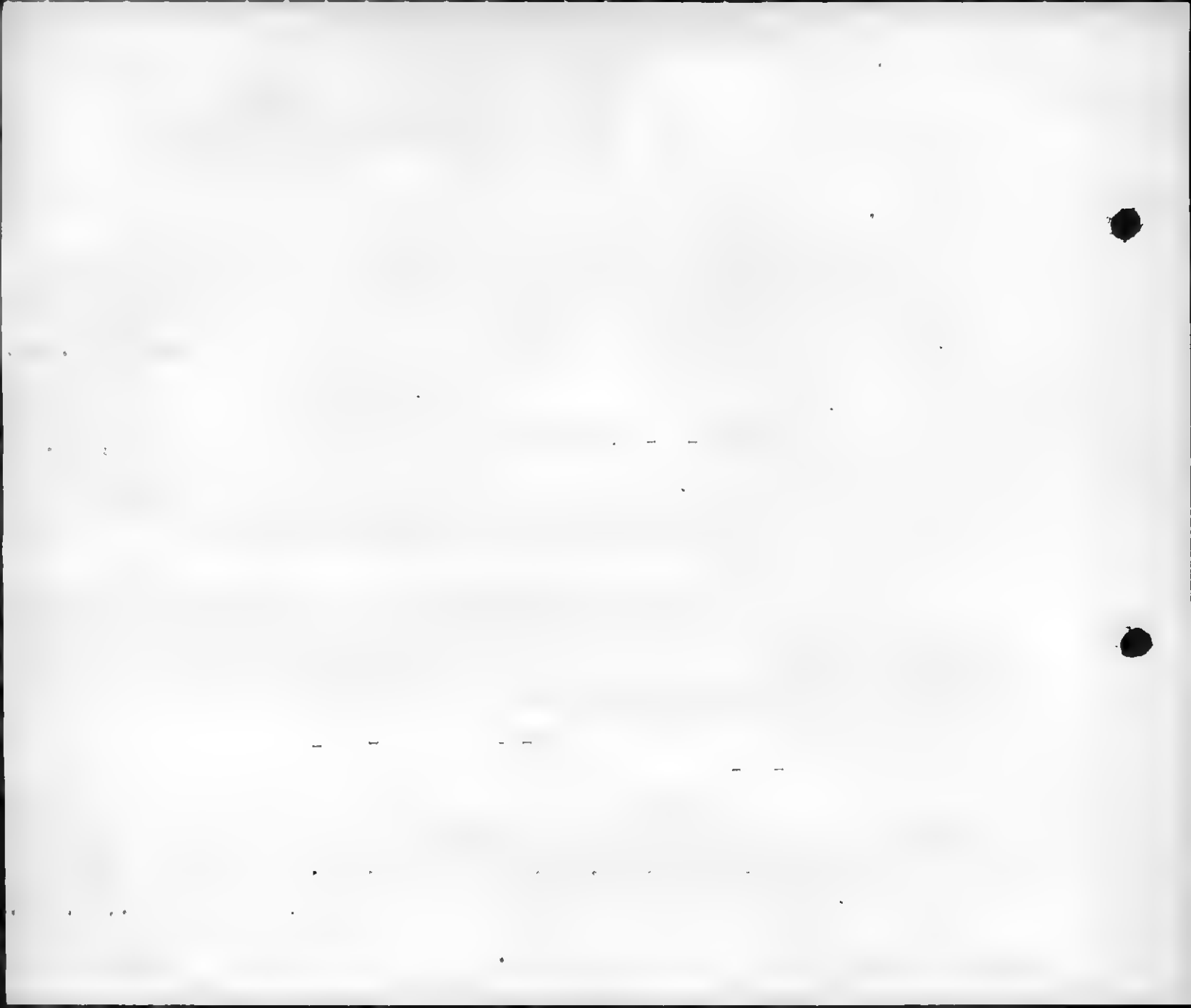
1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Penna. b. COUNTY Greene			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) John First Gillivan Middle Last				4 DATE OF DEATH Month 8 Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1886	
9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mining				10b. KIND OF BUSINESS OR INDUSTRY Coal		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? unk.							
13. FATHER'S NAME unk.				14. MOTHER'S MAIDEN NAME unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO 286-05-1690			
17. INFORMANT Cuppitt Nursing Home				Address Oakland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemiplegia 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Macular Degeneration - Chronic Asthma							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 1957 to Aug 28, 1960 , that I last saw the deceased alive on Aug. 27, 1960 , and that death occurred at 2 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 ARDEN ST OAKLAND MD DATE SIGNED 8/29/60							
ACTUAL SIGNATURE E. L. Baumgartner PHYSICIAN'S NAME (Type) E. L. BAUMGARTNER OAKLAND MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 8/30/60		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harold N. Minnich				ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE SEP 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
9158					09132				
1 PLACE OF DEATH a. COUNTY Garrett MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Garrett				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			c. LENGTH OF STAY IN 1b 21 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland				
d. NAME OF HOSPITAL (If not in hospital, give street address) Garrett Co. Memorial Hospital					d. STREET ADDRESS Route # 2			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dowey Elwood Gnegy			First Middle Last		4. DATE OF DEATH Month August Day 13 Year 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-6-88 1898		9. AGE (In years last birthday) 61 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? America U.S.A.	
13. FATHER'S NAME Joel Gnegy					14. MOTHER'S MAIDEN NAME Jennie Knox Mowery				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no			16. SOCIAL SECURITY NO. 213-18-2838		17. INFORMANT "Wife" Sadie Gnegy		Address Route 2 Oakland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac-renal vascular disease } 5 yrs (c) Arteriosclerosis } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-1-54 to 8-13-60, 1960, that (I) (we) last saw the deceased alive on 8-13-60, 1960, and that death occurred at 12:00 Noon from the causes and on the date stated above.									
22a. SIGNATURE Andrew E. Lance					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 14 Aug 60		
22c. PHYSICIAN'S NAME (Type) Andrew E. Lance, M.D.					22d. ADDRESS Oakland, Md.				
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE THEREOF 8/16/1960		23c. NAME OF CEMETERY OR CREMATORY Egdon Cemetery			23d. LOCATION (City, town or county) (State) Egdon, Preston Co., W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton					ADDRESS Oakland, Md.		25a. REC'D BY REG. STRAR DATE AUG 18 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9159

Item 10, Item 10

CERTIFICATE OF DEATH

09133

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aurora	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		d. STREET ADDRESS 555 X	
3. NAME OF DECEASED (Type or print) First Lucy Middle Ellen Last Haas		4. DATE OF DEATH Month Aug. Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1882
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY W.Va.	11. BIRTHPLACE (State or foreign country) USA
13. FATHER'S NAME Alvin A. McCrum		14. MOTHER'S MAIDEN NAME Margret Shuttleworth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Mrs. Girtrude Hardesty Aurora, W.Va.	
17. INFORMANT Mrs. Girtrude Hardesty Aurora, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatosis 17 DX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma breast DUE TO (c) 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH 4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1959 to Aug 3, 1960 that I last saw the deceased alive on Aug 31, 1960 and that death occurred at M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Chas. E. Smith M.D.		Terra Alta W.Va.	
PHYSICIAN'S NAME (Type) Chas. E. Smith M.D.		W.Va.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 5/60	22c. NAME OF CEMETERY OR CREMATORY Aurora	22d. LOCATION (City, town, or county) (State) Aurora W.Va.
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle		24a. REC'D BY REGISTRAR DATE AUG 12 '60	
ADDRESS Davis, W.Va.		24b. REGISTRAR'S SIGNATURE Orlando E. Hester	

MEDICAL CERTIFICATION

CONF.
R.N.
SENT

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If necessary, may be executed by the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09134

1. PLACE OF DEATH a. COUNTY <u>CALVERT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWIND</u> c. LENGTH OF STAY (In 1b) <u>13 yrs., 45 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>OWIND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEN</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWIND</u> d. STREET ADDRESS <u>0102</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>YAS</u> First Middle Last 5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JUNE 14, 1894</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>19</u> Month <u>02</u> Day <u>19</u> Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COLOMIST</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>KEYSER</u> 11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ARON TUGLER</u> 14. MOTHER'S MAIDEN NAME <u>RACHEL</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>1-21-0-1000-1000-1000</u> 17. INFORMANT <u>EDITH M. TUGLER, OWIND, MD.</u> Address <u>241 1st St. Owind, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUICIDAL ATTEMPT, PASSIVE; LEFT</u> (b) <u>CONTUSIONS OF HEAD, LEFT</u> (c) <u>16 Hrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>no</u>	
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto while accident at route 210 and route 50</u> 20c. TIME OF INJURY Month, Day, Year <u>12:00 a.m. on 2-23-60</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>OWIND, MARYLAND</u> 20f. (City or town) (County) (State) <u>OWIND, MARYLAND (ALLEN CO.)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>James H. Hafer, Jr.</u> M.D. EXAMINER'S NAME (Type) <u>James H. Hafer, Jr.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>August 26, 1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Cumberland, Maryland</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Aug 29 '60</u> 24b. REC'D BY REGISTRAR <u>Arthur L. Hafer</u> 24c. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

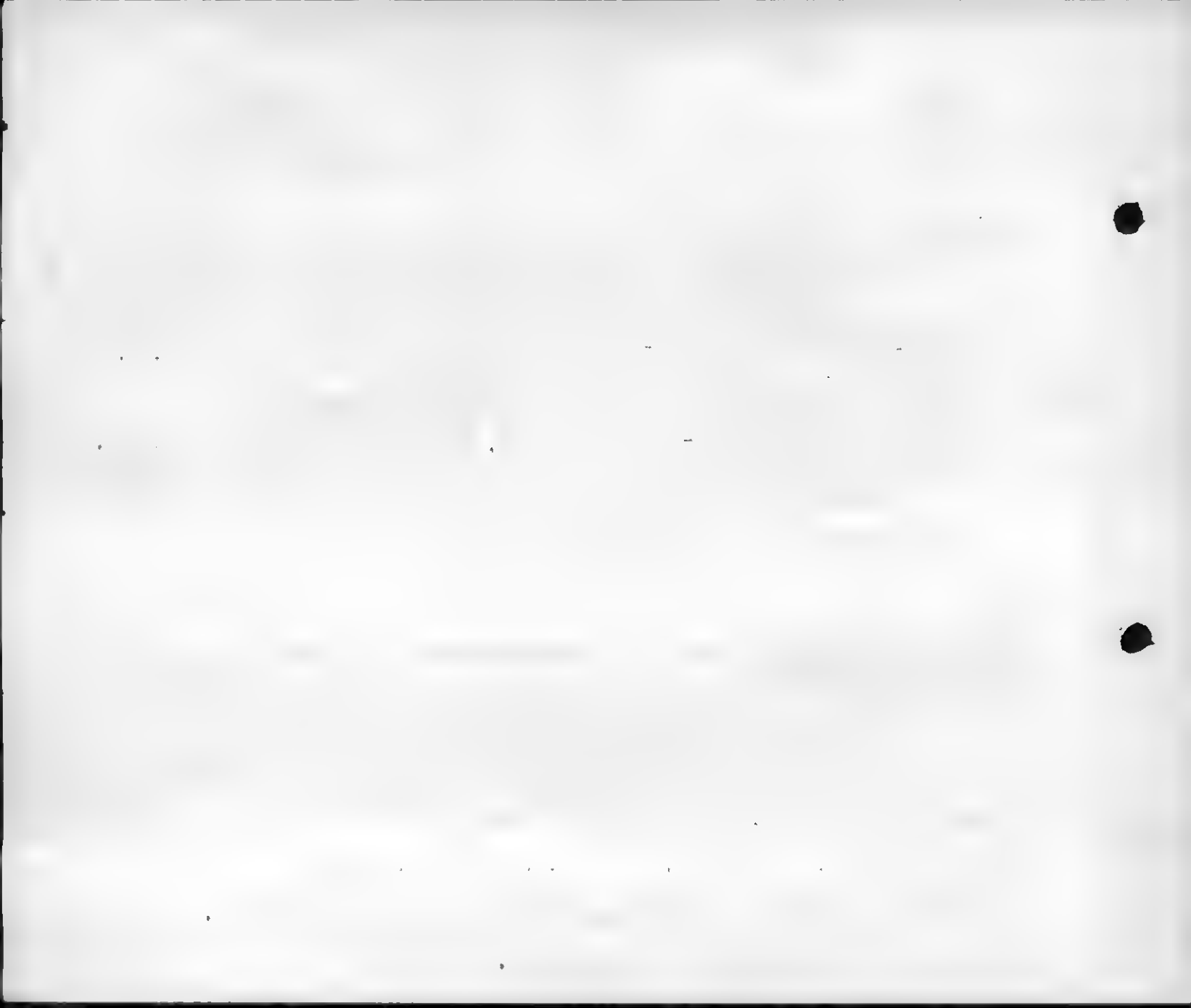
9161

CERTIFICATE OF DEATH

09135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 74, Deer Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy		First Middle Last Hinebaugh		4. DATE OF DEATH August		Day Month Year 3 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1960		9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Mins 1 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Hinebaugh, Earl Thornton				14. MOTHER'S MAIDEN NAME Friend, Freda Pearl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Earl T. Hinebaugh		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 102.0 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 3, 1960 , to August 3, 1960 , that I last saw the deceased alive on August 3, 1960 , and that death occurred at 6:05 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Oakland, Maryland DATE SIGNED 8-3-60							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D. Oakland, Maryland					
PHYSICIAN'S NAME (Type) James H. Feaster, Jr.		M.D. Oakland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/1960		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Al. Leighton</i>				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knaus</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

9162

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09136

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAKLAND</u>				c. LENGTH OF STAY IN 1b <u>5 HOURS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KITZMILLER</u>			
				d. STREET ADDRESS <u>1</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER WASHINGTON KELLER</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 21, 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUN 16, 1904</u>	
9. AGE (In years lost birthday) <u>66</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COAL MINING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>COAL MINING</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
13. FATHER'S NAME <u>RICHARD KELLER</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA STEMPLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>216-10-1344</u>		17. INFORMANT Address <u>MRS. WALTER KELLER, KITZMILLER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage- due to hypertension</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>0</u> hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased arrive on <u>19</u> , and that death occurred at <u>12:20 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Andrew E. Mance</u>				22b. DATE SIGNED <u>21 Aug 60</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR. ANDREW E. MANCE</u>				22d. ADDRESS <u>CAKLAND, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>		23d. LOCATION (City, town, or county) (State) <u>514 Garden W.Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kyle Orth & Kitzmiller, Md</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 26 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Andrew E. Mance</u>	

M

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9176

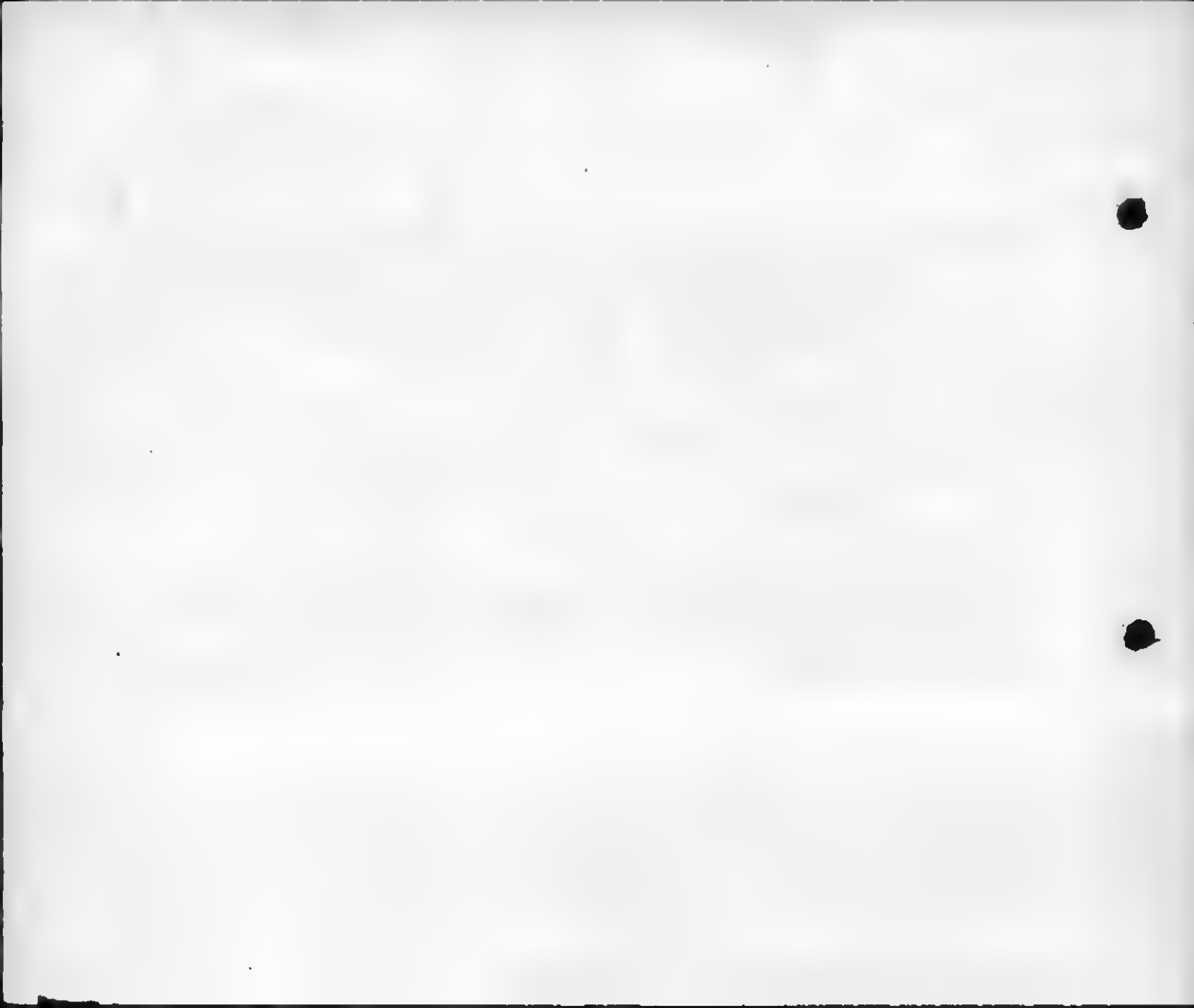
CERTIFICATE OF DEATH

09137
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt# 1, Oakland		c. LENGTH OF STAY IN 1b 13 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt# 1, Oakland	
		f. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carl Martin Kitzmiller		4. DATE OF DEATH Month August Day 22 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31.1911
9. AGE (In years last birthday) 49 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (State or foreign country) Oakland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Kitzmiller		14. MOTHER'S MAIDEN NAME Emily Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO. 218-10-0510	
17. INFORMANT Edna Hardesty, Petersburg, Fla.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STARVATION			
DUE TO (b) CARCINOMA CT JAW &			
DUE TO (c) METASTASES			
INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-17-1950 to 8-22-1960 , that I last saw the deceased alive on 8-20-1960 , and that death occurred at 5 P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE James H. Fisher		M.D. 58-2-1-51 CARL H. L. 8-23-60	
PHYSICIAN'S NAME (Type) JAMES H. FISHER M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 8/24/60	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE General J. Minnich		ADDRESS Oakland, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 26 '60		24b. REGISTRAR'S SIGNATURE James S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the registrar, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

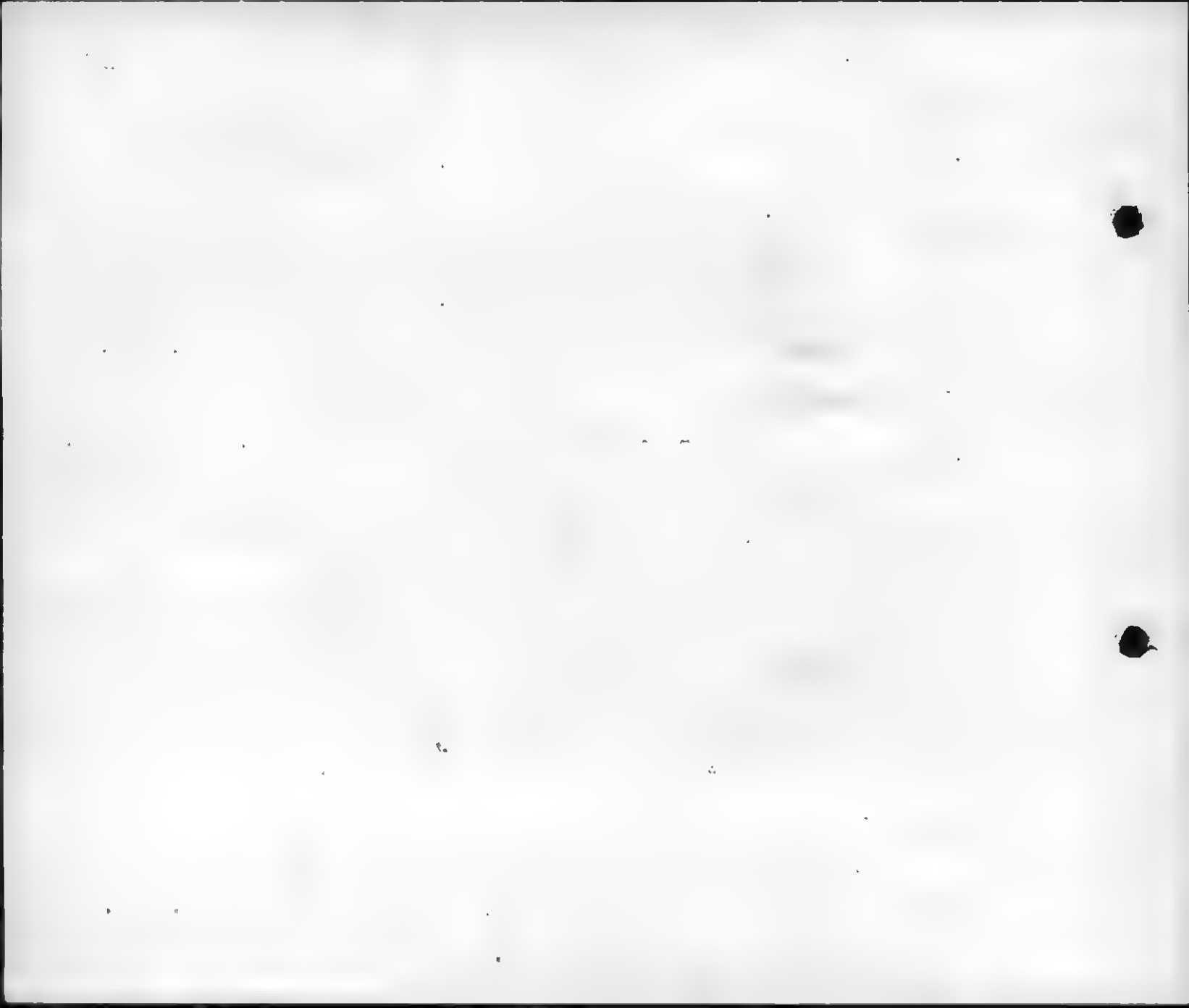
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15M 9/59

9163

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09138

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT CO. MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle HENRY Last KITZMILLER				4. DATE OF DEATH Month AUGUST Day 4 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 27, 1881	
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER Retired				10b. KIND OF BUSINESS OR INDUSTRY Own FARM		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME WILLIAM KITZMILLER				14. MOTHER'S MAIDEN NAME AIRY ANN BACHTEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 212-24-0631		17. INFORMANT (ADA KITZMILLER) WIFE Address MT. LAKE PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarct of brain-stem DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Acute coronary thrombosis + hypotension DUE TO (c) Arteriosclerotic heart disease						INTERVAL BETWEEN ONSET AND DEATH 1 day 2 days 10 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/30, 1960 , to 8/4, 1960 , that (I) (we) last saw the deceased alive on 8/4, 1960 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Richard E. Leighton M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/5/60	
22c. PHYSICIAN'S NAME (Type) DR. RICHARD LEIGHTON M. D.				22d. ADDRESS OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8/6/1960		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley Cemetery Garrett Co., Md.		23d. LOCATION (City, town, or county) (State) Garrett Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. E. Leighton				ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE AUG 8 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Prouse	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

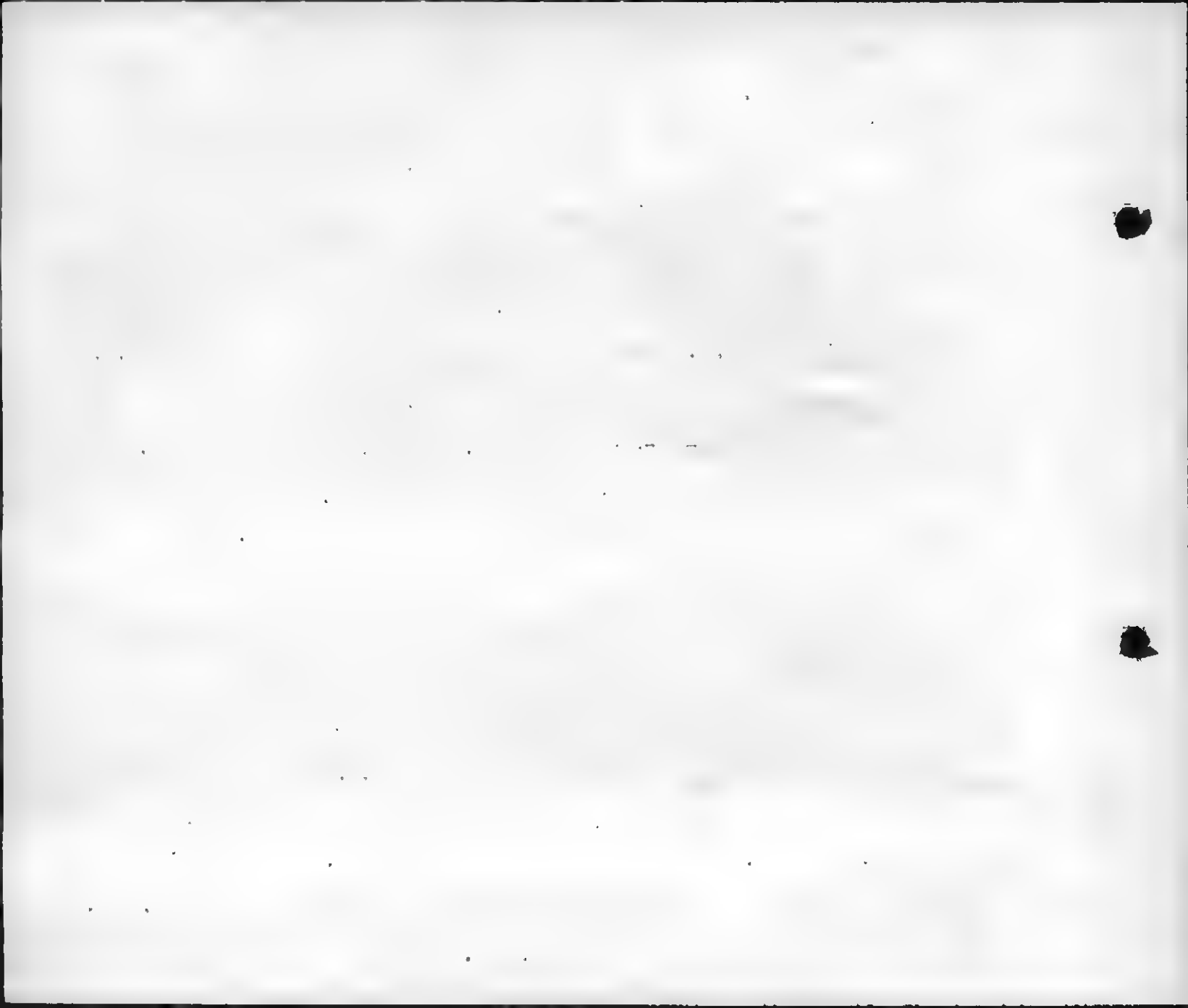
VR A15 (4)
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9164

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09130

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle JACOB Last LANDIS				4. DATE OF DEATH Month AUGUST Day 5 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 1, 1881	
9. AGE (In years last birthday) 79 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Forest Service		10b. KIND OF BUSINESS OR INDUSTRY U.S. National		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME LANDIS, GEORGE W			
14. MOTHER'S MAIDEN NAME KIMBLE, HANNAH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 232-26-3528				17. INFORMANT BERTHA D. SIMMONS, MT. LAKE PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gumonia, bilateral, bacterial INTERVAL BETWEEN ONSET AND DEATH 5 days DUE TO Pneumonia due to ruptured peptic ulcer 3 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Cerebral sclerosis 8 yrs DUE TO Cerebral sclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8 Feb. 1955 to 5 Aug. 1960 that (I) (we) last saw the deceased alive on 5 Aug. 1960 and that death occurred at 2:00 A.M. from the causes and on the date stated above							
22a. SIGNATURE Andrew E. Mance M.D.				22b. DATE SIGNED 8/6/60			
22c. PHYSICIAN'S NAME (Type) DR. ANDREW E. MANCE				22d. ADDRESS OAKLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/1960		23c. NAME OF CEMETERY OR CREMATORY Mayesville Cemetery		23d. LOCATION (City, town, or county) (State) Grant County, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. E. Leighton				25a. REC'D BY REGISTRAR DATE AUG 8 '60		25b. REGISTRAR'S SIGNATURE Clinton S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9165

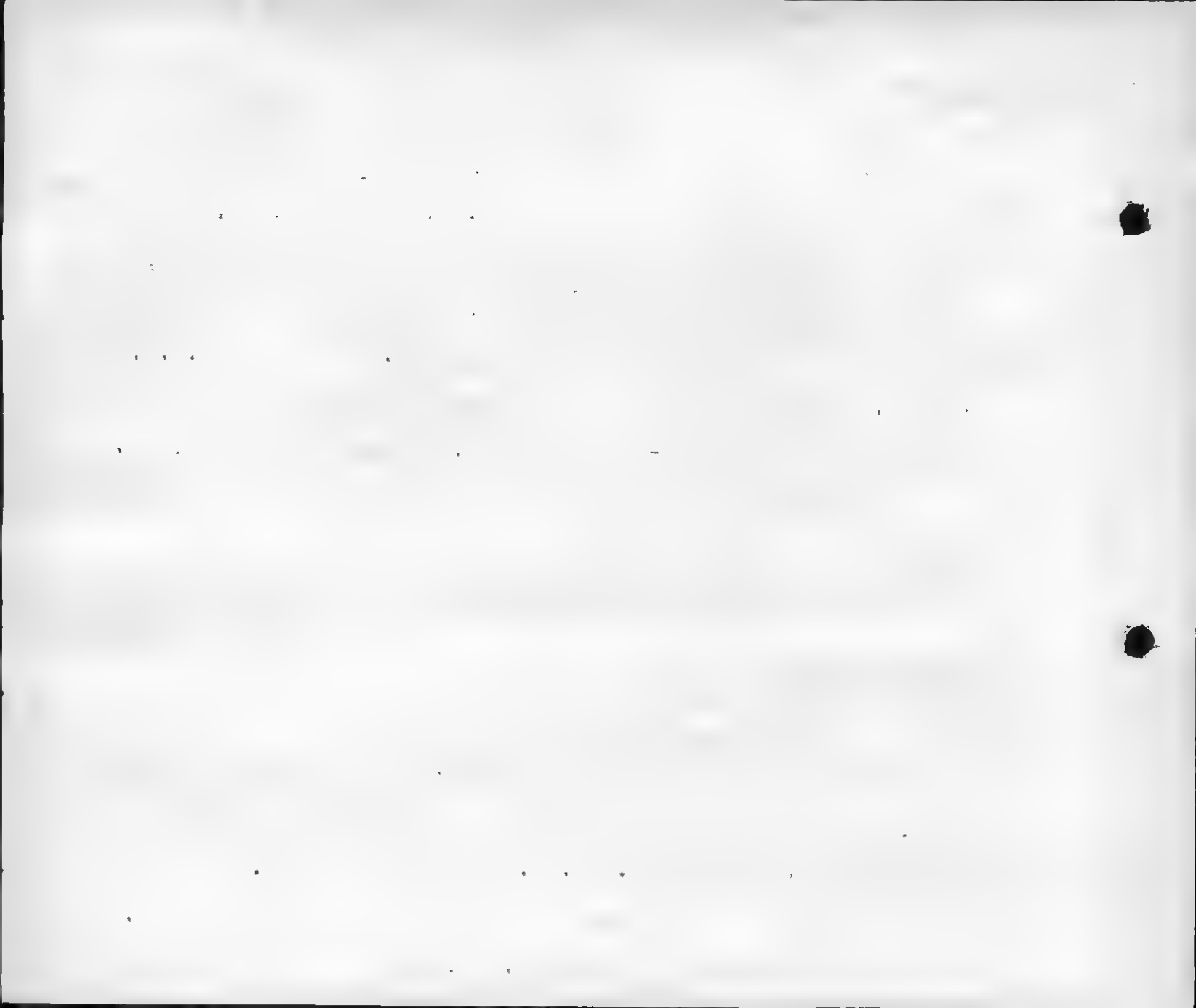
CERTIFICATE OF DEATH

Reg. Dist. No. 49140

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Rest Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nora Middle Haden Last Landis				4. DATE OF DEATH Month August Day 26, Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1889		9. AGE (In years last birthday) yrs. 71	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Landis				14. MOTHER'S MAIDEN NAME Mary Ann Shirk			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Harold R. Landis Address Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Arteriosclerotic Cardio - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Renal Disease						INTERVAL BETWEEN ONSET AND DEATH 3 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-29-60 , 19 60 , to 8-27 , 19 60 , that I last saw the deceased alive on 8-24 , 19 60 , and that death occurred at 1:05 P M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 578 24 St Oakland, Md. DATE SIGNED 8-28-60							
ACTUAL SIGNATURE James H. Feaster Jr.				PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D. Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/1960		22c. NAME OF CEMETERY OR CREMATORY King Cemetery		22d. LOCATION (City, town, or county) (State) near Loch Lynn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Lightfoot ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE SEP 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No. 00141

9177

1 PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Grantsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Grantsville</u>	
c. LENGTH OF STAY IN 1b <u>3 weeks</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Noah</u> Middle <u>J</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>8</u> Day <u>22</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Arthur, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T Lee</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Yoder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>1</u> (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 10, 1960</u> to <u>Aug 22, 1960</u> , that I last saw the deceased alive on <u>Aug 21, 1960</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Garrettsville, Ind.</u> DATE SIGNED <u>8/23/60</u>			
ACTUAL SIGNATURE <u>C. P. Strong</u> M.D.		PHYSICIAN'S NAME (Type) <u>Garrettsville, Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Niverton Amish Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury Rd Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. P. Conlans</u> ADDRESS <u>Meyersdale Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Kinn</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

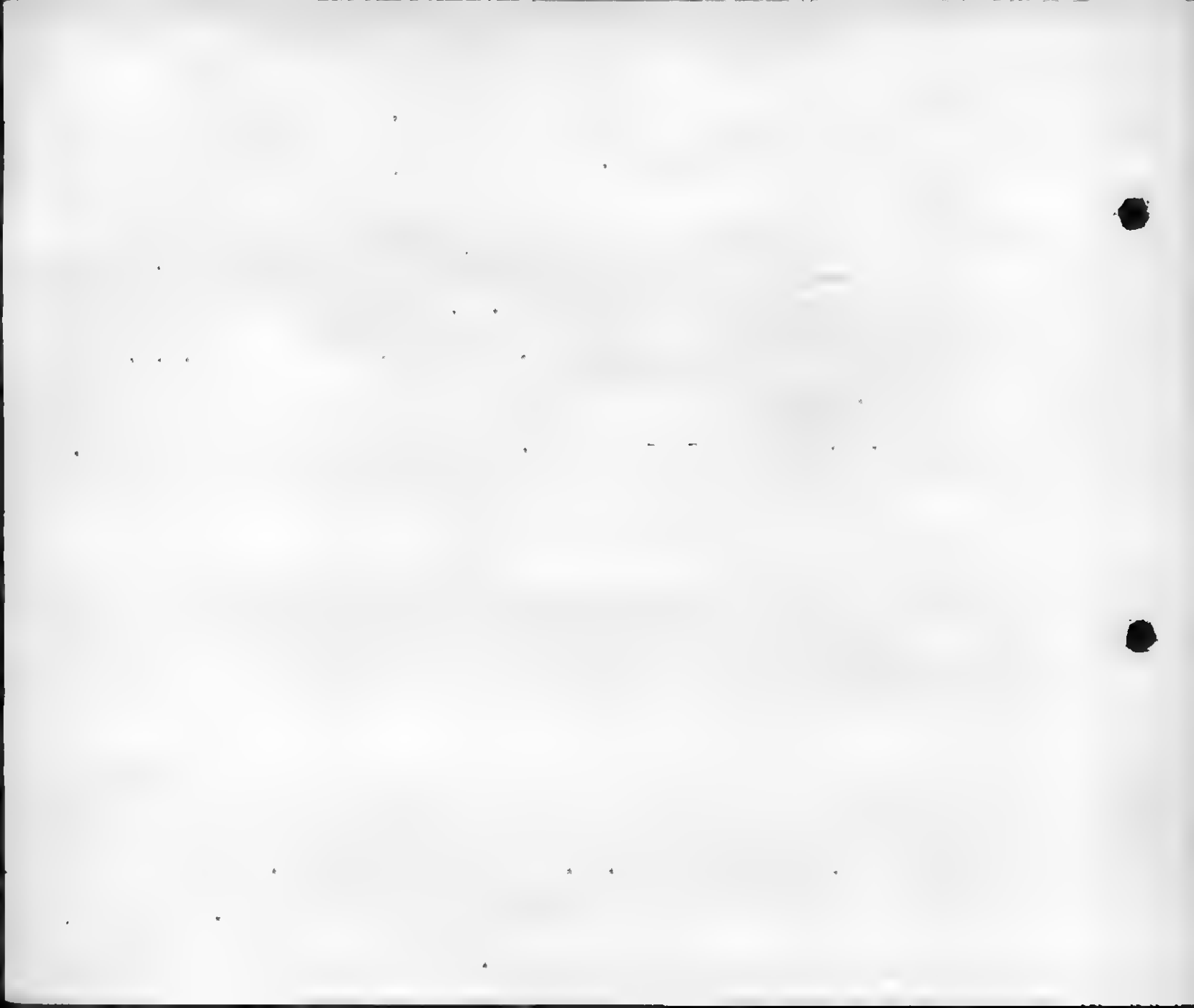
9166

CERTIFICATE OF DEATH

09143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Mason Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gordon Middle Drydan Last McRobie				4. DATE OF DEATH Month August Day 28 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1894	
9. AGE (In years last birthday) 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Appliance Service West Md. Power Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Joseph H. McRobie			
14. MOTHER'S MAIDEN NAME Clara Freeland				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W. W. #1			
16. SOCIAL SECURITY NO. 215-01-9071				17. INFORMANT Mrs. Elizabeth McRobie Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO ARTERIO SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS (c) ARTERIO SCLEROSIS INTERVAL BETWEEN ONSET AND DEATH INSTANT							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANXIETY NEOROSIS - 5 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour 19 Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3/26/46 19____, to 8/28/60 19____, that I last saw the deceased alive on 8/27/60 19____, and that death occurred at 10:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. I. Baumgartner M.D.				ADDRESS (Street, city or town, state) 2520 DEN ST		DATE SIGNED 8/29/60	
PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. Oakland, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/31/1960		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE SEP 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

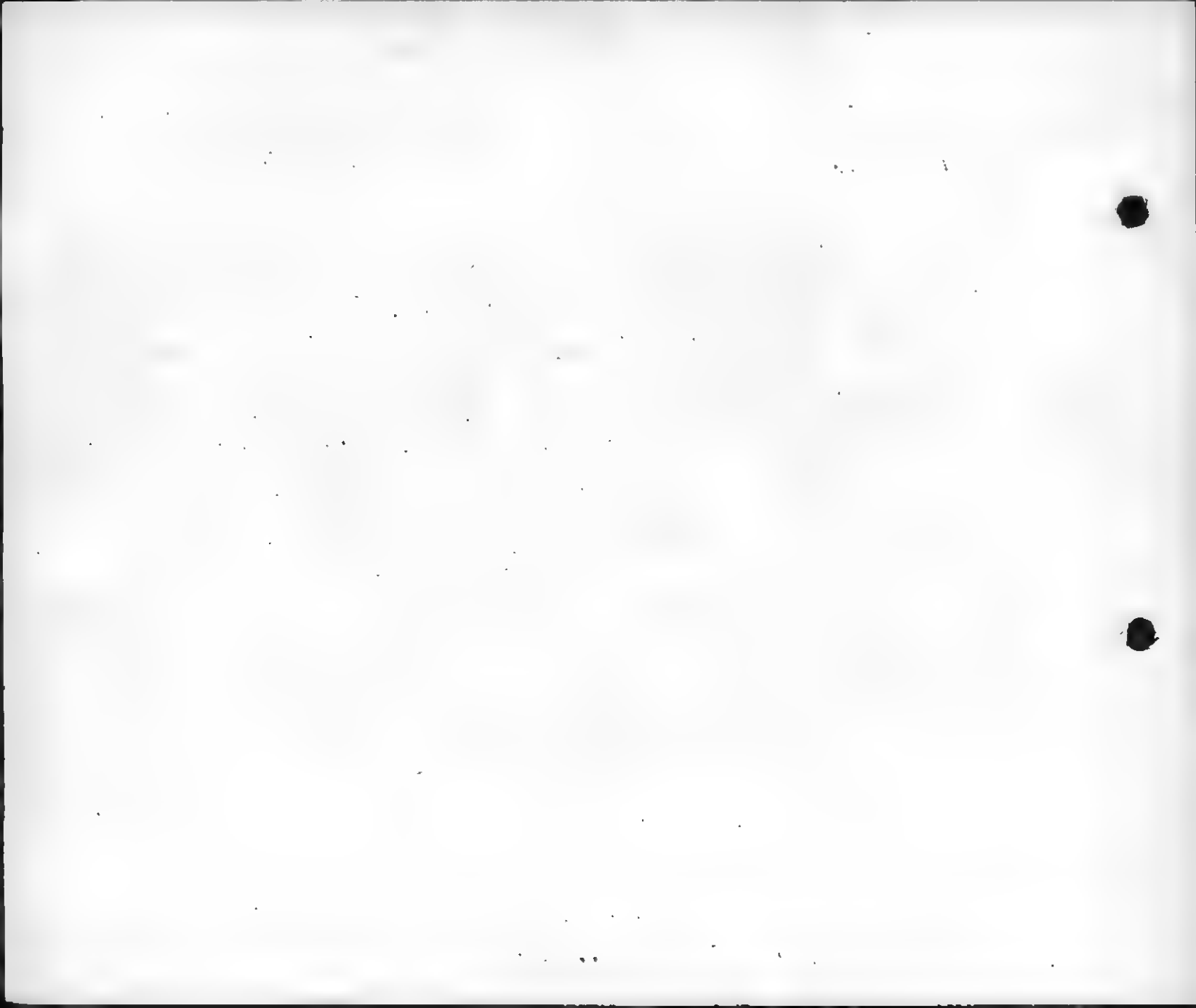
9178

CERTIFICATE OF DEATH

Reg. Dist. No. 09144

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF CHRISTOPHER First Middle Last		4. DATE OF DEATH Month AUG. Day 3 Year 1960	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 19, 1886
9. AGE (In year last birthday) 73 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
11. BIRTHPLACE (State or foreign country) FROSTBURG MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME HENRY MERRBACH		14. MOTHER'S MAIDEN NAME CHRISTINA BOWERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 196-22-0735	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) with Congestive failure		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/11 , 19 60 to 8/3 , 19 60 that I last saw the deceased alive on 8/1 , 19 60 , and that death occurred at 8:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 345 Main St Meyersdale Pa			
ACTUAL SIGNATURE D. C. Glassman		DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/6/60	
22c. NAME OF CEMETERY OR CREMATORY MERRBACH		22d. LOCATION (City, town, or county) (State) GARRETT Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Harrison		24a. REC'D BY REGISTRAR DATE AUG 8 '60	
ADDRESS Grantsville Md		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



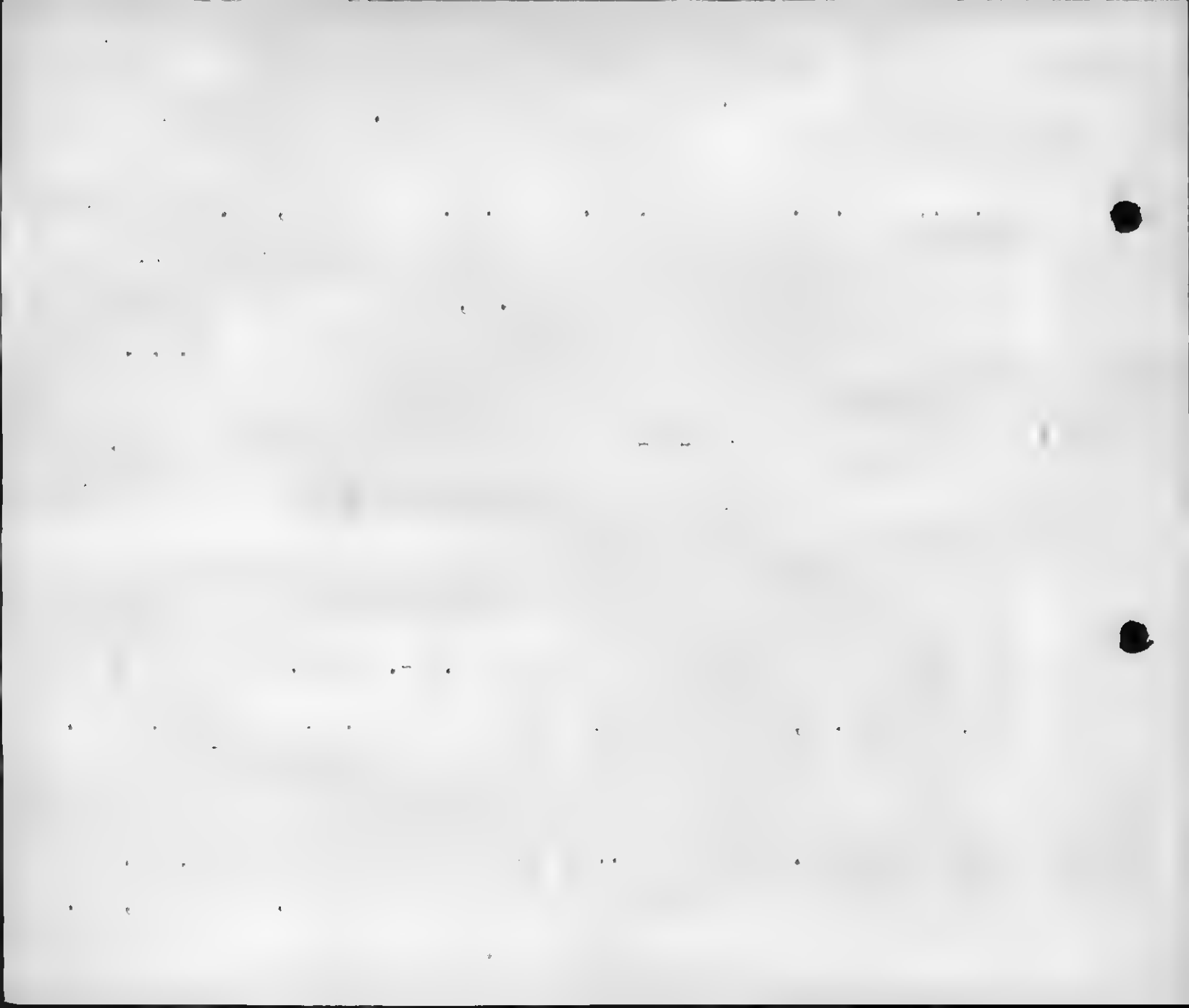
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: 1. Certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9179
Divisi
MARYLAND STATE DEPARTMENT OF HEALTH
STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09145

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Deer Park c. LENGTH OF STAY IN b 30 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R. D., 5 Mi. S. Deer Park, Md.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence, colored admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Deer Park d. STREET ADDRESS R. D., Deer Park, Md.	
3. NAME OF DECEASED (Type or print) Albert First Manuel Middle Moon Last		4. DATE OF DEATH Month August Day 9, Year 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8, 1890	
9. AGE (In years) IF UNDER 1 YEAR Last birthday 70 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Coal Miner Self employed		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Moon		14. MOTHER'S MAIDEN NAME Anna Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-12-8917	
17. INFORMANT George Moon (Son)		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decapitation secondary to self inflicted gunshot wound of head DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in head with .30-.30 cal. soft nose rifle slug	
20c. TIME OF INJURY Month, Day, Year 10:30 a.m. Aug. 9, 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence		20f. (City or town) (County) (State) Garrett Rt. 1, Deer Park, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/10/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/12/1960	
22c. NAME OF CEMETERY OR CREMATORY Henry Beckman Cemetery near Mt. Lake Park, Md.		22d. LOCATION (City, town, or country) (State) Oakland, Md.	
23. FUNERAL DIRECTOR H. C. Leighton		24a. REC'D BY REGISTRAR AUG 15 '60	
ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	



TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9167

09146

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>28 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>52 Pennington St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur E. Naylor Sr.</u>		First Middle Last		4. DATE OF DEATH <u>August 11 1960</u>		Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1890</u>	9. AGE (in years last birthday) <u>70</u> yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS
10a. USULA. OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Hardware</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America U.S.A.</u>	
13. FATHER'S NAME <u>Alonzo D. Naylor</u>				14. MOTHER'S MAIDEN NAME <u>Artie Bartlett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>"Wife" Ruth M. Naylor,</u>		Address <u>52 Pennington St. Oakland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Embolism</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>Aug 11</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug 11</u> , 19 <u>60</u> , and that death occurred on <u>Aug 11</u> , 19 <u>60</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James H. Feaster Jr.</u>				22b. DATE <u>8/12/60</u>		22c. PHYSICIAN'S NAME (Type) <u>James H. Feaster Jr., M. D.,</u>	
22d. ADDRESS <u>Oakland, Maryland</u>				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/13/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oakland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. E. Reighton</u>				25a. REC'D BY REGISTRAR <u>AUG 15 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
ADDRESS <u>Oakland, Md.</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9168

09147

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WARDER REESE NETHKEN				4. DATE OF DEATH AUGUST 7 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 2, 1919	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL BROKER		10b. KIND OF BUSINESS OR INDUSTRY Brokage		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NETHKEN, JOSEPH				14. MOTHER'S MAIDEN NAME BRANT, Clara Brandt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-03-8859		17. INFORMANT CAROLINE NETHKEN, 1929 PARK AVE, BALTIMORE 17, D.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular Disorder DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Aug 5 1960 to Aug 7 1960 that (I) (we) last saw the deceased alive on Aug 7 1960 and that death occurred at 1:25 A.M. from the causes and on the date stated above							
22a. SIGNATURE E. I. Baumgartner				M D ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/9/60	
22c. PHYSICIAN'S NAME (Type) DR. E. I. BAUMGARTNER				22d. ADDRESS OAKLAND, MD.			
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 8/9/60		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edward J. Pinnick				ADDRESS Oakland, Maryland		25a. REC'D BY REGISTRAR AUG 10 '60	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9180

CERTIFICATE OF DEATH

09148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park, c. LENGTH OF STAY IN 1b 10 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Point, Deep Creek Lake		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park, d. STREET ADDRESS Pen Point, Deep Creek Lake e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Jennings Last Ritchey		4. DATE OF DEATH Month August Day 20, Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1897
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 65 Days 65 Hours 65 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Owner Auto Tire Sales		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Ritchey		14. MOTHER'S MAIDEN NAME Catherine Jay	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) yes W.W.#1		16. SOCIAL SECURITY NO. 163-10-4589	
17. INFORMANT (Wife) Esther Mae Ritchey		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) 15 years		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/11/1960 to 8/20/1960 , that I last saw the deceased alive on 8/20/1960 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 21 Aug 60	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/22/1960	22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery	22d. LOCATION (City, town, or county) (State) Deer Park, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. K. K. K. ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR AUG 26 60 DATE	
		24b. REGISTRAR'S SIGNATURE W. E. K. K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: Certificate should be executed within 24 hours after death. If an affidavit is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

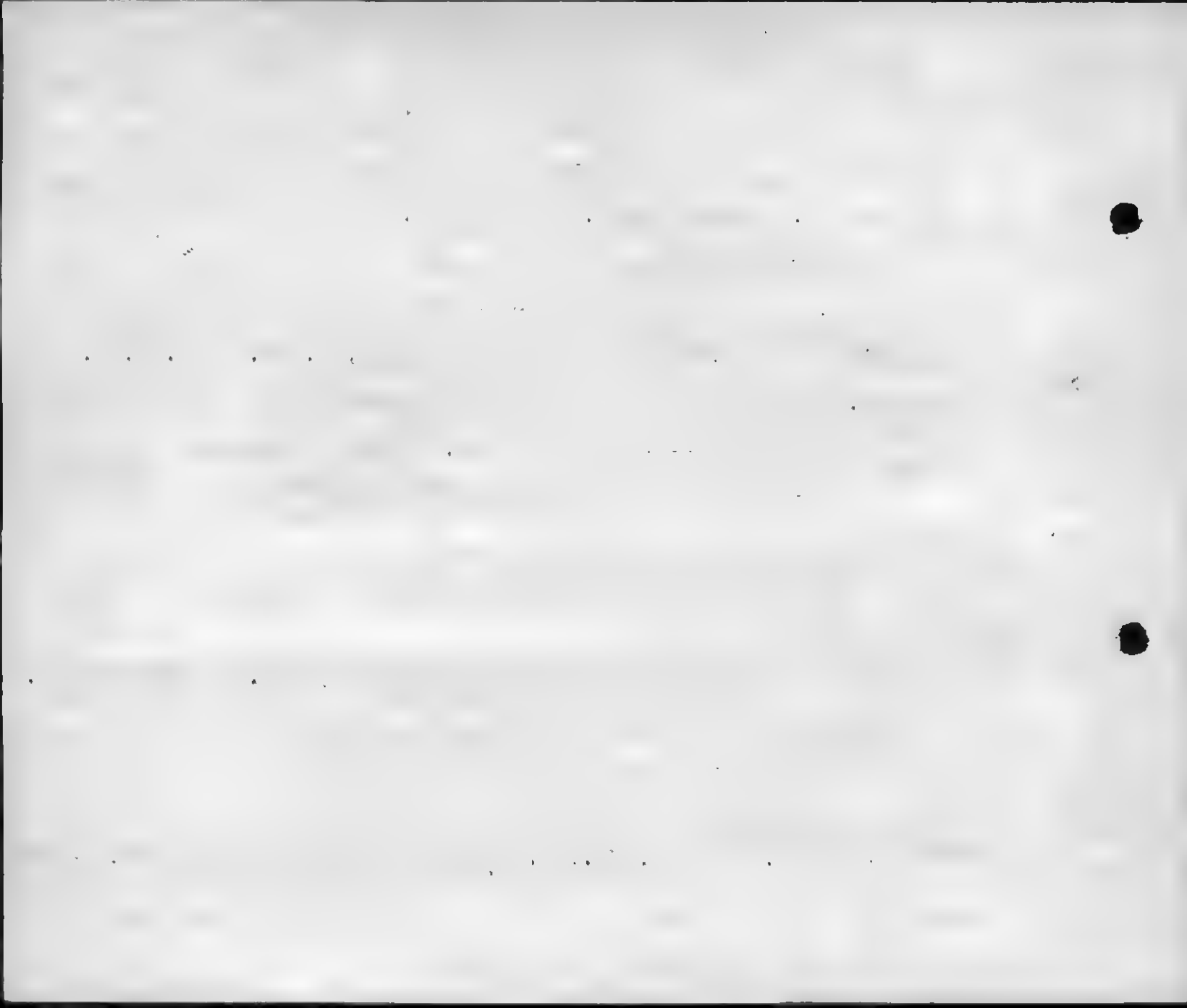
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

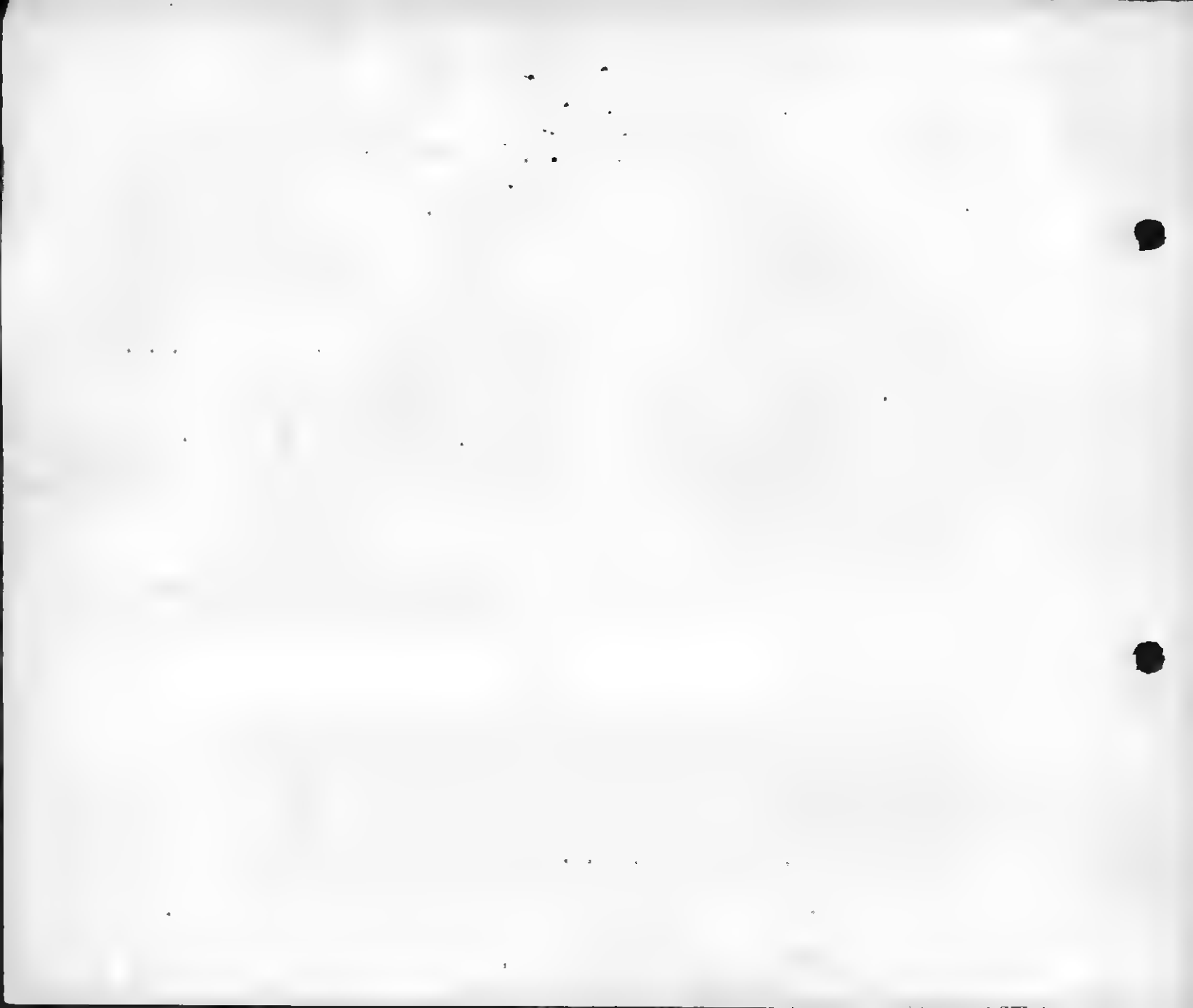
9169 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00149

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN b 23 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett C. Memorial Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland d. STREET ADDRESS Rt. 2	
3. NAME OF DECEASED (Type or print) Anna May Schoch 4. DATE OF DEATH Month 8 Day 1 Year 19 60		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 1-17-1896 9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Terra Alta, W. Va. 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James B. Nordeck 14. MOTHER'S M.A.DEN NAME Fannie Riley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. ---- 17. INFORMANT Mrs. Geraldine Glotfelty Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage into brain tumor 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell out of bed at home 6-15-60, unk. if head struck.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 3 weeks		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 6-15-60 Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE James H. Feaster, Jr. M.D. EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D. Address (Street, city, town, or county) Oakland, Md. 8-2-60		22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 8/3/60 22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery 22d. LOCATION (City, town, or country) (State) Oakland Md.	
23. FUNERAL DIRECTOR Gerald N. Winnick ADDRESS Oakland, Md. 24a. REC'D BY REGISTRAR AUG 8 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION





1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: certificate should be executed within 24 hours after death. If delay is necessary, it should be executed within 72 hours after death. Page 5 may be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FMS-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09151

1. PLACE OF DEATH
a. COUNTY **CARROLL** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **BLOOMINGTON**
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **W. Va.** b. COUNTY **HAMPSHIRE**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **LEVELS**
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☒

3. NAME OF DECEASED (Type or print) **CLARENCE MORELAND SNYDER**
4. DATE OF DEATH **AUG. 2, 1960**
5. SEX **MALE** 6. COLOR OR RACE **WHITE** 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **July 18, 1934**
8. AGE (In years last birthday) **26** yrs. IF UNDER 1 YEAR: Months **2** Days **10** IF UNDER 24 HRS: Hours **19** Min. **00**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **W. Va.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **CHARLES GEORGE SNYDER** 14. MOTHER'S MAIDEN NAME **MARY ELLEN MORELAND**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, state or unknown) 16. SOCIAL SECURITY NO. **375-56-3523** 17. INFORMANT **Mr. Charles Snyder,** Address **same**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **FRACTURED SKULL**
DUE TO (b) **CHLORIDE OF PHOSPHORUS**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) **WENT INTO CHEMICAL TRUCK**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **deceased was asleep in his parked truck which in turn was struck by a runaway chemical truck Rt. 135, Bloomington, Md.**
20c. TIME OF INJURY Month, Day, Year **5:05 a.m. AUG. 2 19 60** 20d. INJURY OCCURRED While ☒ at work Not While ☐ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Street** 20f. (City or town) **Bloomington, Garr., Mdd.** (State) **(State)**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **James H. Snyder, Jr.** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **JAMES H. SNYDER, JR., M.D.** ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED **AUG 4, 1960**
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

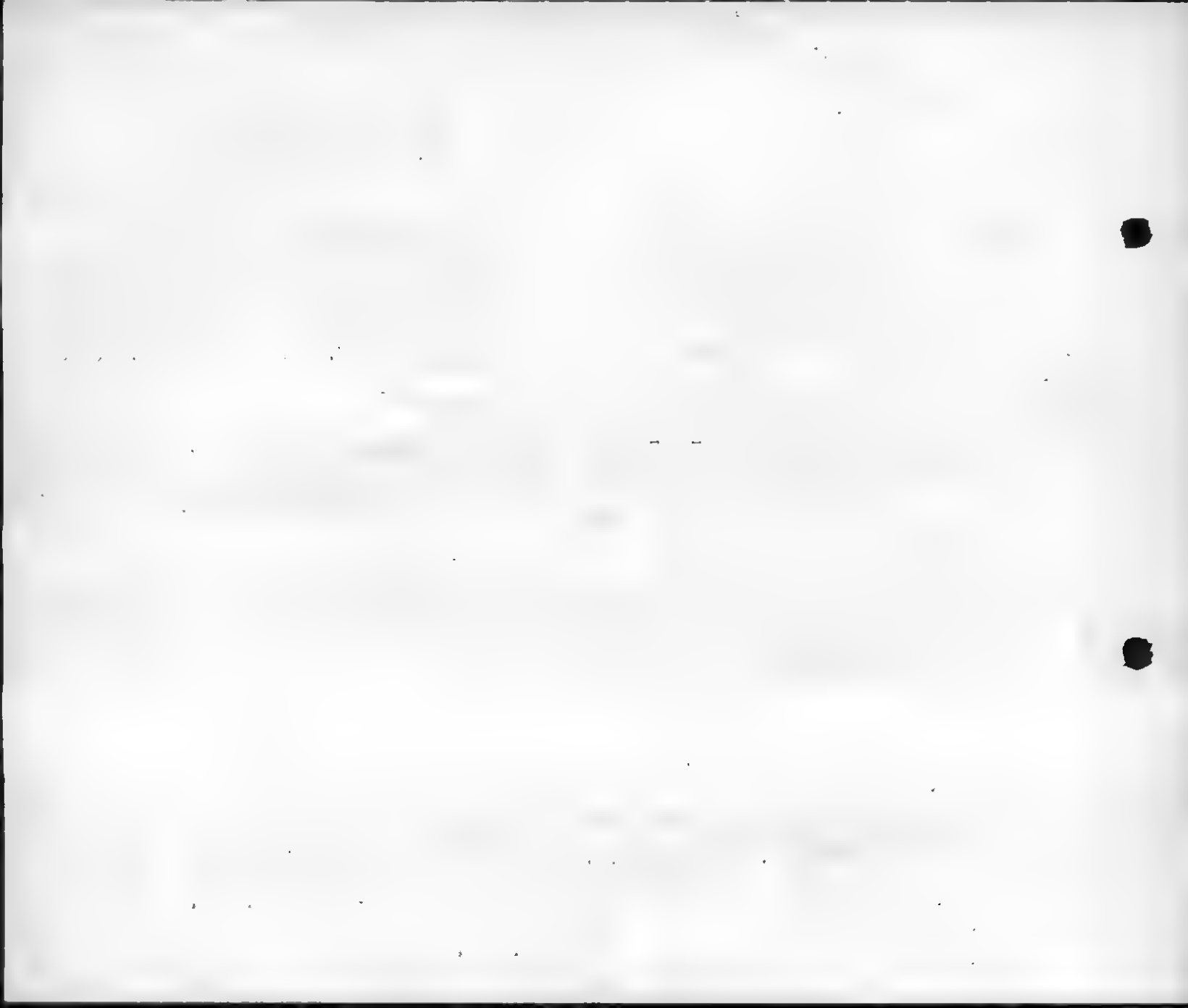
22a. BURIAL, CREMATION, OR REMOVAL (Specify) **Burial** 22b. DATE THEREOF **8/5/60** 22c. NAME OF CEMETERY OR CREMATORY **Levels Cemetery** 22d. LOCATION (City, town, or country) **Levels, W. Va.** (State)

23. FUNERAL DIRECTOR **E. C. Boal - Westminster, Md.** ADDRESS **Westminster, Md.** 24a. REC'D BY REGISTRAR **AUG 4 '60** 24b. REGISTRAR'S SIGNATURE **Arthur L. Kline**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <div>9171</div> <div> <div>1</div> <div>M</div> <div>I</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>09152</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL						2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First PITCHARD Middle SOLLARS Last SOLLARS				4. DATE OF DEATH Month AUGUST Day 14 Year 1960							
5 SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 16, 1883		9 AGE (In years last birthday) 77 yrs		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal MINER				10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines				11 BIRTHPLACE (State or foreign country) ELK GARDEN, W. VA.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME THOMAS SOLLARS						14. MOTHER'S MAIDEN NAME JANE JUNKINS					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-03-7217		17 INFORMANT MARGARET SOLLARS Address DEER PARK, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema + Bilateral Cor Pulmonale DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Chronic Bronchitis DUE TO Chronic Bronchitis (c) Chronic Bronchitis										INTERVAL BETWEEN ONSET AND DEATH 1 Month 5 years Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from March 1957 to Aug 14, 1960, that (I) (we) last saw the deceased alive on Aug 14, 1960, and that death occurred at 4:15 A.M. from the causes and on the date stated above.											
22a SIGNATURE Herbert H. Leighton M.D.						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 14 Aug. 60			
22c PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.						22d. ADDRESS 77 Oak Street, Oakland, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE THEREOF 8/17/1960		23c NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		23d LOCATION (City, town, or county) Deer Park, Md. (State)			
24. MEDICAL DIRECTOR'S SIGNATURE H. Leighton						ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE AUG 18 '60		25b. REGISTRAR'S SIGNATURE O. L. & H. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

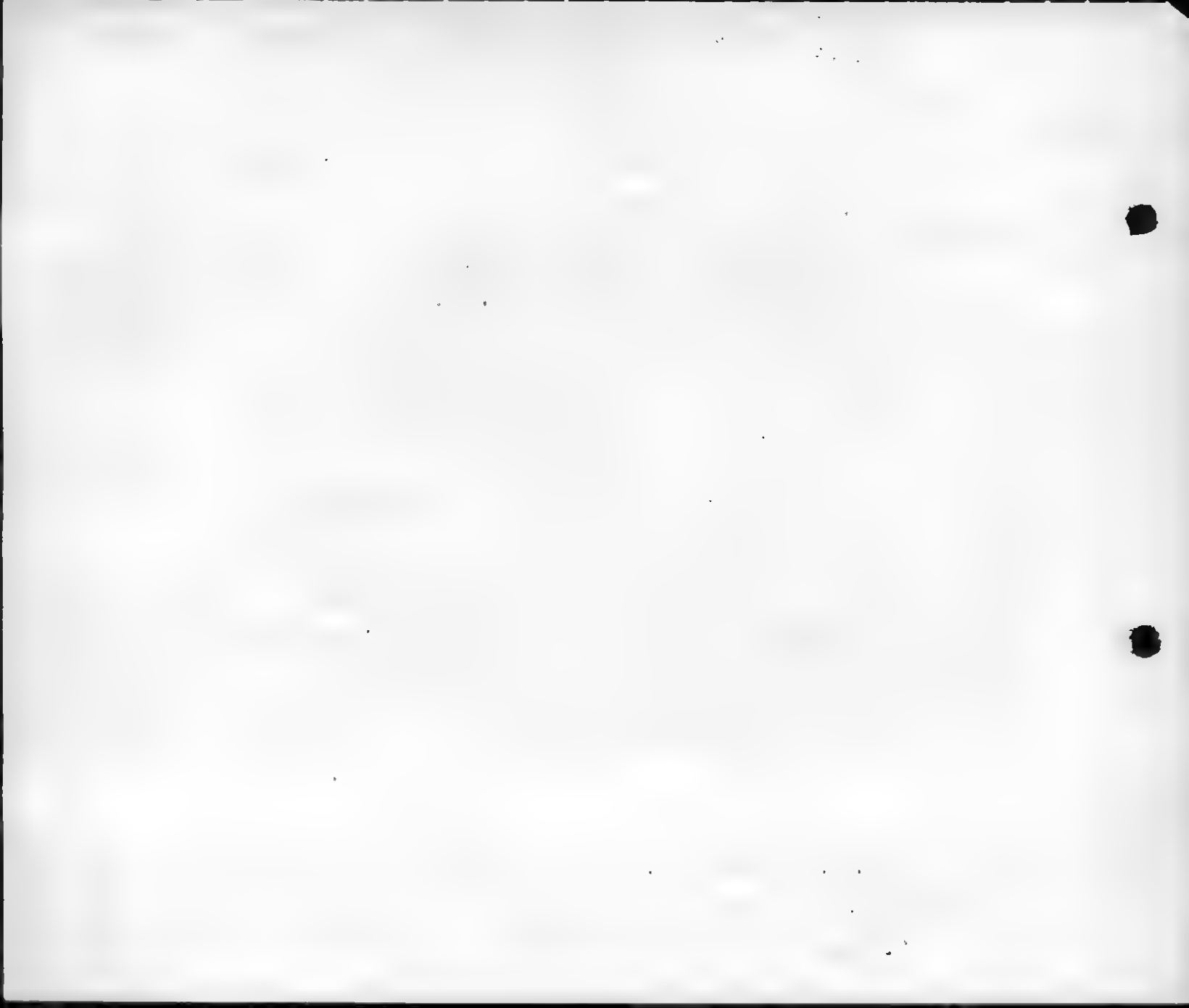
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9172

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09153

1 PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 25 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT CO. MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LEWIS Middle LEE Last STEWART				4. DATE OF DEATH Month AUGUST Day 7 Year 1960			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH SEPT. 14, 1890	9 AGE (In years last birthday) yrs 69	IF UNDER 1 YEAR Months 11 Days 7	IF UNDER 24 HRS Hours 7 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ROWLESBURG, W. VA.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL STEWART				14 MOTHER'S MAIDEN NAME ELIZABETH SUSAN SYPODT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17 INFORMANT Address (MABEL STEWART WIFE) HUTTON, MARYLAND			
18 CAUSE OF DEATH [Enter on any one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Advanced Myocardial Arteriosclerosis DUE TO (c) Stroke Heart Disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombocytopenic Purpura - Hypochromic Anemia						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 7/10/60 19 to 8/7/60 19, that (I) (we) last saw the deceased alive on 8/6/60 19, and that death occurred at 8:55 A.M. the causes and on the date stated above.							
22a SIGNATURE E. I. Baumgartner M. D.				22b DATE SIGNED 8/12/60		22c PHYSICIAN'S NAME (Type) E. I. BAUMGARTNER M. D.	
23a BURIAL CREMATION REMOVAL (Specify) Removal & Burial		23b DATE THEREOF 8/10/60		23c NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		23d LOCATION (City, town, or county) (State) Terra Alta, West Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE Md. F.D. License A8305				25a REC'D BY REGISTRAR DATE AUG 12 '60		25b REGISTRAR'S SIGNATURE Arthur S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09154

Reg. Dist. No.

9182

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville, Md.		c. LENGTH OF STAY IN 1b All of life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS none	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Manilla Middle Gladys Last Thomas Umble		4. DATE OF DEATH Month August Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1899
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 23 Days 19 Hours 60 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hosea Thomas		14. MOTHER'S MAIDEN NAME Ida Belle Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Chlen Umble		Address Friendsville, Maryland	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Gall Bladder 155 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Mitastases to Liver, Intestines, Lung DUE TO (c) (operation July 1, 60 Bishopston)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) Secondary Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1960 to Aug 23, 1960 , that I last saw the deceased alive on Aug 22, 1960 , and that death occurred at 3 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin M. Price MD		ADDRESS (Street, city or town, state) DATE SIGNED 612 Logan Place, Friendsville, Md. 12	
PHYSICIAN'S NAME (Type) Edwin M. Price MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/26/60	22c. NAME OF CEMETERY OR CREMATORY Sand Spring Cemetery	22d. LOCATION (City, town, or county) (State) Garrett, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Estimate Brandonville		24a. REC'D BY REGISTRAR SEP 6 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Chlen S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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9173

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09155

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 60 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT CO. MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GILBERT Middle CARROLL Last WEINER				4. DATE OF DEATH Month AUGUST Day 1 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 OCT. 1879	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 9 Days 6 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEMAN		10b. KIND OF BUSINESS OR INDUSTRY WOODS		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JESSE WEINER				14. MOTHER'S MAIDEN NAME ELIZABETH FRIEND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-01-6000		17. INFORMANT (MARY E. WEINER) BOX #252 MT. LAKE PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Terminal 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD DUE TO (c) Seps						INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-19 1955 to 7-31 1960 that (I) (we) last saw the deceased alive on 7-31 1960 , and that death occurred at 9:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Andrew E. Mance				22b. DATE SIGNED 1 Aug 60		22c. PHYSICIAN'S NAME (Type) ANDREW E. MANCE M. D.	
22d. ADDRESS OAKLAND, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/3/1960		23c. NAME OF CEMETERY OR CREMATORY Ferndale Cemetery		23d. LOCATION (City, town, or county) (State) near Oakland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton				25a. REC'D BY REGISTRAR DATE AUG 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

9173

RECEIVED BY MAIL

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UNITED STATES

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9183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Deer Park,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. 5 Mi. N. Deer Park, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ralph Middle Everett Last Wright				4. DATE OF DEATH Month August Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 3, 1887	
9. AGE (In years, months, days) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Wood Working		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John A. Wright				14. MOTHER'S MAIDEN NAME Flora McRobie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-1025		17. INFORMANT Mrs. Emma Wright Address R. D. Deer Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage with rt sided paralysis DUE TO Hypertension (c) 53yo.							INTERVAL BETWEEN ONSET AND DEATH 3 days (2 weeks) Aug 7 '60
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1955 to August 21, 1960 , that I last saw the deceased alive on Aug 20, 1960 , and that death occurred at 5:00A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph Calandrella				M.D. Kitzmill, Md. ADDRESS (Street, city or town, state) Aug 22-60			
PHYSICIAN'S NAME (Type) Ralph Calandrella, M. D.				DATE SIGNED Aug 22-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/1960		22c. NAME OF CEMETERY OR CREMATORY George Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. L. Leighton				ADDRESS Oakland, Md.		24b. REGISTRAR'S SIGNATURE William S. Hume	
24a. REC'D BY REGISTRAR AUG 26 '60							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19
1913
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of death: _____
5. Place of death: _____
6. Cause of death: _____
7. Signature of physician: _____
8. Signature of registrar: _____
9. Date of registration: _____
10. Place of registration: _____